

		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0044271</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Grasmere Place</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/04</u> to <u>12/31/04</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>	
Address: <u>4621 N. Sheridan Rd</u> <u>Chicago</u> <u>60640</u>			
Number City Zip Code			
County: <u>Cook</u>			
Telephone Number: <u>(773) 334-6601</u> Fax # <u>(773) 334-3619</u>			
IDPA ID Number: <u>364269374001</u>			
Date of Initial License for Current Owners: <u>02/01/99</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		<input checked="" type="checkbox"/> PROPRIETARY	
<input type="checkbox"/> Charitable Corp.		<input type="checkbox"/> Individual	
<input type="checkbox"/> Trust		<input type="checkbox"/> Partnership	
IRS Exemption Code <u> </u>		<input type="checkbox"/> Corporation	
		<input type="checkbox"/> "Sub-S" Corp.	
		<input checked="" type="checkbox"/> Limited Liability Co.	
		<input type="checkbox"/> Trust	
		<input type="checkbox"/> Other <u> </u>	
In the event there are further questions about this report, please contact:			
Name: <u>Steve Lavenda</u>		Telephone Number: <u>(847) 236 - 1111</u>	

Officer or Administrator of Provider	(Signed) _____
	(Type or Print Name) _____
	(Title) _____
Paid Preparer	(Signed) _____
	(Date) _____
	(Print Name and Title) <u>Edward N. Slack, C.P.A.</u>
	(Firm Name & Address) <u>Frost, Ruttenberg & Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u>
	(Telephone) <u>(847) 236-1111</u> Fax # <u>(847) 236-1155</u>
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number	Grasmere Place
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#	0044271	Report Period Beginning:	01/01/04	Ending:	12/31/04
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III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds

D. How many bed-hold days during this year were paid by Public Aid?

1,944 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)

None

F. Does the facility maintain a daily midnight census?

Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?

YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 2/1/99

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 2/1/99 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified and days of care provided

Medicare Intermediary

IV. ACCOUNTING BASIS

ACCUAL	X	MODIFIED CASH*		CASH*	
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Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/04 **Fiscal Year:** 12/31/04

*** All facilities other than governmental must report on the accrual basis.**

1		2		3		4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period			
1		Skilled (SNF)					1
2		Skilled Pediatric (SNF/PED)					2
3	216	Intermediate (ICF)	216	79,056			3
4		Intermediate/DD					4
5		Sheltered Care (SC)					5
6		ICF/DD 16 or Less					6
7	216	TOTALS	216	79,056			7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	74,778			74,778	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	74,778			74,778	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.59%

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	178,272	31,092	9,973	219,337		219,337	(3,020)	216,317			1
2	Food Purchase		285,166		285,166	(32,794)	252,372		252,372			2
3	Housekeeping	208,536	40,102		248,638		248,638	(5,429)	243,209			3
4	Laundry		8,203	27,226	35,429		35,429		35,429			4
5	Heat and Other Utilities			125,901	125,901		125,901	1,869	127,770			5
6	Maintenance	101,320		128,578	229,898		229,898	574	230,472			6
7	Other (specify):*							5,003	5,003			7
8	TOTAL General Services	488,128	364,563	291,678	1,144,369	(32,794)	1,111,575	(1,003)	1,110,572			8
	B. Health Care and Programs											
9	Medical Director			7,200	7,200		7,200		7,200			9
10	Nursing and Medical Records	996,132	26,383	47,238	1,069,753		1,069,753	20,192	1,089,945			10
10a	Therapy											10a
11	Activities	249,754	10,866	12,455	273,075		273,075		273,075			11
12	Social Services	507,059	15,494	3,252	525,805		525,805	13,442	539,247			12
13	Nurse Aide Training											13
14	Program Transportation			1,125	1,125		1,125		1,125			14
15	Other (specify):*							5,370	5,370			15
16	TOTAL Health Care and Programs	1,752,945	52,743	71,270	1,876,958		1,876,958	39,004	1,915,962			16
	C. General Administration											
17	Administrative	89,262		24,343	113,605		113,605	16,976	130,581			17
18	Directors Fees											18
19	Professional Services			365,045	365,045	(15,772)	349,273	(285,936)	63,337			19
20	Dues, Fees, Subscriptions & Promotions			53,037	53,037		53,037	(20,961)	32,076			20
21	Clerical & General Office Expenses	118,248	18,826	304,080	441,154		441,154	(48,572)	392,582			21
22	Employee Benefits & Payroll Taxes			429,257	429,257	32,794	462,051	(5,513)	456,537			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,332	1,332		1,332	4,960	6,292			24
25	Other Admin. Staff Transportation			6,543	6,543		6,543	(5,110)	1,433			25
26	Insurance-Prop.Liab.Malpractice			119,937	119,937		119,937	1,012	120,949			26
27	Other (specify):*							27,525	27,525			27
28	TOTAL General Administration	207,510	18,826	1,303,574	1,529,910	17,022	1,546,932	(315,619)	1,231,312			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,448,583	436,132	1,666,522	4,551,237	(15,772)	4,535,465	(277,618)	4,257,847			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			105,431	105,431		105,431	306,577	412,008			30
31	Amortization of Pre-Op. & Org.							2,637	2,637			31
32	Interest							331,556	331,556			32
33	Real Estate Taxes					15,772	15,772	264,267	280,039			33
34	Rent-Facility & Grounds			948,000	948,000		948,000	(942,173)	5,827			34
35	Rent-Equipment & Vehicles			11,087	11,087		11,087	2,241	13,328			35
36	Other (specify):*							44,397	44,397			36
37	TOTAL Ownership			1,064,518	1,064,518	15,772	1,080,290	9,502	1,089,792			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			118,584	118,584		118,584		118,584			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			118,584	118,584		118,584		118,584			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,448,583	436,132	2,849,624	5,734,339		5,734,339	(268,117)	5,466,222			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(82,475)	30		9
10	Interest and Other Investment Income	(199,624)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(60,000)	21		24
25	Fund Raising, Advertising and Promotional	(242)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,065)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(194,187)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (538,093)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	269,977		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 269,977		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (268,117)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Grasmere Place

ID#	0044271
Report Period Beginning:	01/01/04
Ending:	12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Other Income	\$ (223)	21	1
2	Jury Duty Income	(86)	10	2
3	Theft Loss	(120)	21	3
4	Collections	(9)	21	4
5	Building Company - Audit Fee	(8,400)	19	5
6	Building Company - Bank Fee	(7)	21	6
7	Building Company - Trust Fee	(196)	21	7
8	Building Company - Filing Fee	(450)	21	8
9	COPE Dues	(3,466)	20	9
10	Penalty	(525)	20	10
11	Auto Tickets	(250)	25	11
12	Prior Year Legal	(341)	19	12
13	Capitalized R&M	(8,079)	06	13
14	Duplicated Expense	(1,748)	19	14
15	Non-Allowable Expense	(170,287)	21	15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
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97				97
98				98
99				99
100				100
101	Total	(194,187)		101

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/04 Ending: 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS	
													(to Sch V, col.7)	
1	Dietary				(88)	490		(3,422)					(3,020)	1
2	Food Purchase													2
3	Housekeeping				(5,429)								(5,429)	3
4	Laundry													4
5	Heat and Other Utilities					1,869							1,869	5
6	Maintenance	(8,079)				1,996		6,657					574	6
7	Other (specify):*						3,376	1,627					5,003	7
8	TOTAL General Services	(8,079)			(5,517)	4,355	3,376	4,862					(1,003)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(86)			(2,987)			23,265					20,192	10
10a	Therapy													10a
11	Activities													11
12	Social Services							13,442					13,442	12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*							5,370					5,370	15
16	TOTAL Health Care and Programs	(86)			(2,987)			42,077					39,004	16
	C. General Administration													
17	Administrative							16,976					16,976	17
18	Directors Fees													18
19	Professional Services	(10,489)	8,400			(283,847)							(285,936)	19
20	Fees, Subscriptions & Promotions	(4,733)				(16,228)							(20,961)	20
21	Clerical & General Office Expenses	(232,357)	653		(223)	18,229		165,126					(48,572)	21
22	Employee Benefits & Payroll Taxes			(651)	(269)		(4,593)						(5,513)	22
23	Inservice Training & Education													23
24	Travel and Seminar					4,960							4,960	24
25	Other Admin. Staff Transportation	(250)				(4,860)							(5,110)	25
26	Insurance-Prop.Liab.Malpractice					1,012							1,012	26
27	Other (specify):*						1,104	26,421					27,525	27
28	TOTAL General Administration	(247,829)	9,053	(651)	(492)	(280,734)	(3,489)	208,523					(315,619)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(255,994)	9,053	(651)	(8,996)	(276,379)	(113)	255,462					(277,618)	29

Summary B

12/31/04

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(82,475)	370,522			18,530							306,577	30
31	Amortization of Pre-Op. & Org.		2,637										2,637	31
32	Interest	(199,624)	531,180										331,556	32
33	Real Estate Taxes		261,958			2,309							264,267	33
34	Rent-Facility & Grounds		(948,000)			5,827							(942,173)	34
35	Rent-Equipment & Vehicles					2,241							2,241	35
36	Other (specify):*		44,397										44,397	36
37	TOTAL Ownership	(282,099)	262,694			28,907							9,502	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers													44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(538,093)	271,747	(651)	(8,996)	(247,472)	(113)	255,462					(268,117)	45

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		
				Grasmere Real Estate, LLC		Building Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent	\$ 948,000	Grasmere Real Estate, LLC	100.00%	\$	\$ (948,000)	1
2	V	32	Interest Income	917	Grasmere Real Estate, LLC	100.00%		(917)	2
3	V	21	Bank Service Charge		Grasmere Real Estate, LLC	100.00%	7	7	3
4	V	21	Trust Fee		Grasmere Real Estate, LLC	100.00%	196	196	4
5	V	21	Filing Fee		Grasmere Real Estate, LLC	100.00%	450	450	5
6	V	31	Amortization		Grasmere Real Estate, LLC	100.00%	2,637	2,637	6
7	V	33	Real Estate Tax		Grasmere Real Estate, LLC	100.00%	261,958	261,958	7
8	V	32	Interest - HUD		Grasmere Real Estate, LLC	100.00%	532,097	532,097	8
9	V	36	MIP Insurance		Grasmere Real Estate, LLC	100.00%	44,508	44,508	9
10	V	19	Audit Fee		Grasmere Real Estate, LLC	100.00%	8,400	8,400	10
11	V	30	Depreciation		Grasmere Real Estate, LLC	100.00%	370,522	370,522	11
12	V	36	Real Estate Tax Refund	111				(111)	12
13	V								13
14	Total			\$ 949,028			\$ 1,220,775	\$ * 271,747	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22	EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 119,889	\$ 119,889	15
16	V								16
17	V								17
18	V								18
19	V	22	EMPLOYEE HEALTH INSURANCE	120,540	CCS EMPLOYEE BENEFIT GROUP	100.00%		(120,540)	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 120,540			\$ 119,889	\$ * (651)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	DIETARY	\$ 594	XCEL MEDICAL SUPPLY, LLC	100.00%	\$ 506	\$ (88)	15
16	V	02	FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03	HOUSEKEEPING	36,594	XCEL MEDICAL SUPPLY, LLC	100.00%	31,164	(5,429)	17
18	V	04	LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06	REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%			19
20	V	10	NURSING	20,133	XCEL MEDICAL SUPPLY, LLC	100.00%	17,146	(2,987)	20
21	V	10A	THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12	SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21	CLERICAL & GENERAL OFFICE	1,501	XCEL MEDICAL SUPPLY, LLC	100.00%	1,278	(223)	23
24	V	22	EMPLOYEE BENEFITS	1,816	XCEL MEDICAL SUPPLY, LLC	100.00%	1,547	(269)	24
25	V	39	ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%			25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 60,638			\$ 51,642	\$ * (8,996)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary	\$	Care Centers, Inc.	100.00%	\$ 490	\$ 490	15
16	V	05	Utilities		Care Centers, Inc.	100.00%	1,869	1,869	16
17	V	06	Maintenance		Care Centers, Inc.	100.00%	1,996	1,996	17
18	V	10	Nursing		Care Centers, Inc.	100.00%			18
19	V	11	Activities		Care Centers, Inc.	100.00%			19
20	V	19	Professional Fees	293,910	Care Centers, Inc.	100.00%	10,063	(283,847)	20
21	V	20	Dues and Subscriptions	19,710	Care Centers, Inc.	100.00%	3,482	(16,228)	21
22	V	21	Office & Clerical		Care Centers, Inc.	100.00%	18,229	18,229	22
23	V	24	Travel and Seminar		Care Centers, Inc.	100.00%	4,960	4,960	23
24	V	26	Insurance		Care Centers, Inc.	100.00%	1,012	1,012	24
25	V	30	Depreciation		Care Centers, Inc.	100.00%	18,530	18,530	25
26	V	32	Interest		Care Centers, Inc.	100.00%			26
27	V	33	Real Estate Taxes		Care Centers, Inc.	100.00%	2,309	2,309	27
28	V	34	Rent - Building		Care Centers, Inc.	100.00%	5,827	5,827	28
29	V	35	Rent - Equipment and Auto		Care Centers, Inc.	100.00%	2,241	2,241	29
30	V	25	Bus Reimbursement	4,860	Care Centers, Inc.	100.00%		(4,860)	30
31	V	02	Food		Care Centers, Inc.	100.00%			31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 318,480			\$ 71,008	\$ * (247,472)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	06	Maintenance Salary	\$ 23,076	Care Centers, Inc.	100.00%	\$ 23,076	\$	15
16	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	3,376	3,376	16
17	V	10	Nursing Salary		Care Centers, Inc.	100.00%			17
18	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			18
19	V	11	Activity Salary		Care Centers, Inc.	100.00%			19
20	V	12	Social Service Salary		Care Centers, Inc.	100.00%			20
21	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%			21
22	V	17	Administration Salary	2,630	Care Centers, Inc.	100.00%	2,630		22
23	V	21	Office Salary	4,913	Care Centers, Inc.	100.00%	4,913		23
24	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	1,104	1,104	24
25	V	22	Employee Benefits	4,593	Care Centers, Inc.	100.00%		(4,593)	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 35,212			\$ 35,099	\$ * (113)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	01	Dietary Salary	\$ 7,884	Care Centers, Inc.	100.00%	\$ 4,462	\$ (3,422)	15
16	V	03	Housekeeping Salary		Care Centers, Inc.	100.00%			16
17	V	06	Maintenance Salary		Care Centers, Inc.	100.00%	6,657	6,657	17
18	V	07	Emp. Ben. - Gen. Serv.		Care Centers, Inc.	100.00%	1,627	1,627	18
19	V	10	Nursing Salary		Care Centers, Inc.	100.00%	23,265	23,265	19
20	V	10a	Rehab Salary		Care Centers, Inc.	100.00%			20
21	V	12	Social Services Salary		Care Centers, Inc.	100.00%	13,442	13,442	21
22	V	15	Emp. Ben. - Healthcare		Care Centers, Inc.	100.00%	5,370	5,370	22
23	V	17	Administration Salary		Care Centers, Inc.	100.00%	16,976	16,976	23
24	V	21	Office Salary		Care Centers, Inc.	100.00%	165,126	165,126	24
25	V	27	Emp. Ben. - Gen. Admin.		Care Centers, Inc.	100.00%	26,421	26,421	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 7,884			\$ 263,346	\$ * 255,462	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eric Rothner	Relative	Administrative		See Attached	1.57	3.40%	Mgmt Fees	\$ 9,713	17-3	1
2	Adam Vales	Owner	Clerical	6.71%	See Attached	0.78	1.95%	Alloc Salary	809	22-7	2
3	Mark Steinberg	Relative	Administrative		See Attached	1.50	2.73%	Alloc Salary	3,045	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 13,567		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.
Street Address 2201 MAIN STREET
City / State / Zip Code EVANSTON, IL 60202
Phone Number (847)905-4000
Fax Number (847)905-4040

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	<u>22</u>	<u>EMPLOYEE HEALTH INSURANCE</u>	<u>DIRECT ALLOCATION</u>			\$	\$		\$ 119,889	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 119,889	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization XCEL MEDICAL SUPPLY, LLC
Street Address 2201 MAIN STREET
City / State / Zip Code EVANSTON, IL 60202
Phone Number (847)328-7600
Fax Number (847)328-7615

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	01	DIETARY	Direct Allocation			\$	\$		\$ 506	1
2	02	FOOD	Direct Allocation							2
3	03	HOUSEKEEPING	Direct Allocation						31,164	3
4	04	LAUNDRY	Direct Allocation							4
5	06	REPAIRS & MAINTENANCE	Direct Allocation							5
6	10	NURSING	Direct Allocation						17,146	6
7	10A	THERAPY	Direct Allocation							7
8	12	SOCIAL SERVICE	Direct Allocation							8
9	21	CLERICAL & GENERAL OFFICE	Direct Allocation						1,278	9
10	22	EMPLOYEE BENEFITS	Direct Allocation						1,547	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$ 51,642	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Care Centers, Inc.
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	01	Dietary	Patient Days	1,484,397	42	\$ 9,730	\$	74,778	\$ 490	1
2	05	Utilities	Patient Days	1,484,397	42	37,103		74,778	1,869	2
3	06	Maintenance	Patient Days	1,484,397	42	39,622		74,778	1,996	3
4	10	Nursing	Patient Days	1,484,397	42			74,778		4
5	11	Activities	Patient Days	1,484,397	42			74,778		5
6	19	Professional Fees	Patient Days	1,484,397	42	199,755		74,778	10,063	6
7	20	Dues and Subscriptions	Patient Days	1,484,397	42	69,116		74,778	3,482	7
8	21	Office & Clerical	Patient Days	1,484,397	42	361,868		74,778	18,229	8
9	24	Travel and Seminar	Patient Days	1,484,397	42	98,454		74,778	4,960	9
10	26	Insurance	Patient Days	1,484,397	42	20,081		74,778	1,012	10
11	30	Depreciation	Patient Days	1,484,397	42	367,842		74,778	18,530	11
12	32	Interest	Patient Days	1,484,397	42			74,778		12
13	33	Real Estate Taxes	Patient Days	1,484,397	42	45,838		74,778	2,309	13
14	34	Rent - Building	Patient Days	1,484,397	42	115,677		74,778	5,827	14
15	35	Rent - Equipment & Auto	Patient Days	1,484,397	42	44,486		74,778	2,241	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,409,572	\$		\$ 71,008	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Care Centers, Inc.
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	06	Maintenance Salary	Direct Cost			264,919	264,919		23,076	1
2	07	Emp. Ben. - Gen. Serv.	Direct Cost			38,757			3,376	2
3	10	Nursing Salary	Direct Cost			209,584	209,584			3
4	10a	Rehab Salary	Direct Cost			66,982	66,982			4
5	11	Activity Salary	Direct Cost							5
6	12	Social Service Salary	Direct Cost			66,710	66,710			6
7	15	Emp. Ben. - Healthcare	Direct Cost			50,220				7
8	17	Administration Salary	Direct Cost			38,431	38,431		2,630	8
9	21	Office Salary	Direct Cost			525,935	525,935		4,913	9
10	27	Emp. Ben. - Gen. Admin.	Direct Cost			82,566			1,104	10
11	22	Employee Benefits								11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,344,103	\$ 1,172,560		\$ 35,099	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization Care Centers, Inc.
Street Address 2201 West Main Street
City / State / Zip Code Evanston, Illinois 60202
Phone Number (847) 905-3000
Fax Number (847) 905-3030

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary	Facility	Allocation	
	Line	Item	(i.e.,Days, Direct Cost,	Total Units	Subunits Being	Cost Being	Cost Contained	Units	(col.8/col.4)x col.6	
	Reference		Square Feet)		Allocated Among	Allocated	in Column 6			
1	01	Dietary Salary	Patient Days	1,484,397	42	88,579	88,579	74,778	4,462	1
2	03	Housekeeping Salary	Patient Days	1,484,397	42			74,778		2
3	06	Maintenance Salary	Patient Days	1,484,397	42	132,146	132,146	74,778	6,657	3
4	07	Emp. Ben. - Gen. Serv.	Patient Days	1,484,397	42	32,292		74,778	1,627	4
5	10	Nursing Salary	Patient Days	1,484,397	42	461,827	461,827	74,778	23,265	5
6	10a	Rehab Salary	Patient Days	1,484,397	42			74,778		6
7	12	Social Services Salary	Patient Days	1,484,397	42	266,840	266,840	74,778	13,442	7
8	15	Emp. Ben. - Healthcare	Patient Days	1,484,397	42	106,602		74,778	5,370	8
9	17	Administration Salary	Patient Days	1,484,397	42	336,976	336,976	74,778	16,976	9
10	21	Office Salary	Patient Days	1,484,397	42	3,277,864	3,277,864	74,778	165,126	10
11	27	Emp. Ben. - Gen. Admin.	Patient Days	1,484,397	42	524,485		74,778	26,421	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 5,227,610	\$ 4,564,232		\$ 263,346	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office
or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Grasmere Place # 0044271 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	HUD		X	Mortgage	\$71,078.00	1/26/99	\$ 9,518,795	\$ 9,408,578			\$ 532,097	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6												6	
7												7	
8	See Supplemental Schedule											8	
9	TOTAL Facility Related				\$71,078.00		\$ 9,518,795	\$ 9,408,578			\$ 532,097	9	
	B. Non-Facility Related*												
10	Interest Income										(199,624)	10	
11	Interest Income (Bldg Co.)										(917)	11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ (200,541)	14	
15	TOTALS (line 9+line14)						\$ 9,518,795	\$ 9,408,578			\$ 331,556	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,508 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8							\$	\$			\$	8							
9												9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital											14							
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

<div>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.</div>				
1. Real Estate Tax accrual used on 2003 report.			\$	124,1181
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	190,6392
3. Under or (over) accrual (line 2 minus line 1).			\$	66,5213
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	197,7464
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.			\$	15,7725
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.				
TOTAL REFUND \$111 For 1997 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	280,0397
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:				
1999	105,434	8	FOR OHF USE ONLY	
2000	113,935	9		
2001	116,897	10	13	FROM R. E. TAX STATEMENT FOR 2003 \$13
2002	118,227	11		
2003	188,330	12	14	PLUS APPEAL COST FROM LINE 5 \$14
2004 Accrual = 2003 Tax \$188,330 x 1.05 = \$197,746			15	LESS REFUND FROM LINE 6 \$15
The refund of RE Tax has not been offset, since 1997 was not a rate setting year.				
Allocation from Care Centers \$2309			16	AMOUNT TO USE FOR RATE CALCULATION \$16

- NOTES:
1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEGrasmere PlaceCOUNTYCook

FACILITY IDPH LICENSE NUMBER0044271

CONTACT PERSON REGARDING THIS REPORTSteve Lavenda

TELEPHONE(847)236-1111FAX #:(847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) Tax Applicable to Nursing Home
Tax Index Number	Property Description	Total Tax	
1. 14-17-214-001-0000	Long Term Care Property	\$ 184,869.30	\$ 184,869.30
2. 14-17-214-002-0000	Long Term Care Property	\$ 1,730.16	\$ 1,730.16
3. 14-17-214-003-0000	Long Term Care Property	\$ 1,730.16	\$ 1,730.16
4. See Attached	Home Office Allocation	\$ 108,873.39	\$ 2,309.00
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$ 297,203.01	\$ 190,638.62

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAMEGrasmere PlaceCOUNTYCook

FACILITY IDPH LICENSE NUMBER0044271

CONTACT PERSON REGARDING THIS REPORTSteve Lavenda

TELEPHONE(847)236-1111FAX #:(847)236-1155

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	Tax Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000

B. General Construction Type: Exterior Brick Frame _____ Number of Stories 4

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☒ YES ☐ NO

If so, please complete the following:

1. Total Amount Incurred: 79,115

2. Number of Years Over Which it is Being Amortized: 30 yrs

3. Current Period Amortization: 2,637

4. Dates Incurred: 2003

Nature of Costs: HUD Closing Costs

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

1		2		3		4	
Use		Square Feet		Year Acquired		Cost	
1	<u>Facility</u>			<u>1999</u>	\$	<u>800,000</u>	1
2	<u>Alloc 2201 Main</u>					<u>17,717</u>	2
3	TOTALS				\$	817,717	3

SEE ACCOUNTANTS' COMPILATION REPORT

11/3/2005 10:04 AM

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4					\$	\$		\$	\$	4
5										5
6										6
7										7
8										8
	Improvement Type**									
9	Various		1999		83,114		20	3,793	3,793	19,959
10	Various		2000		261,172		20	13,191	13,191	61,499
11								-		-
12								-		-
13								-		-
14								-		-
15								-		-
16								-		-
17								-		-
18								-		-
19								-		-
20								-		-
21								-		-
22								-		-
23								-		-
24								-		-
25								-		-
26								-		-
27								-		-
28								-		-
29								-		-
30								-		-
31								-		-
32								-		-
33								-		-
34								-		-
35								-		-
36								-		-

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$	\$	\$	37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)	6,072,860	173,600		184,992	11,392	1,056,491	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)	68,352	2,806		2,806		5,830	68
69	Financial Statement Depreciation		71,801			(71,801)		69
70	TOTAL (lines 4 thru 69)	\$ 6,485,498	\$ 248,207		\$ 204,782	\$ (43,425)	\$ 1,143,779	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 6,485,498	\$ 248,207		\$ 204,782	\$ (43,425)	\$ 1,143,779	1
2	Nurse Call Station R	2001	8,231		20	412	412	1,647	2
3	Laundry Room Leak Re	2001	4,748		20	237	237	949	3
4	Piping Repair	2001	532		20	27	27	107	4
5		2001	600		20	30	30	120	5
6	New Rods Drapes	2001	765		20	38	38	153	6
7	Heating System Repai	2001	2,283		20	114	114	447	7
8	Water Leak Repair	2001	1,208		20	60	60	236	8
9	Heating System Repai	2001	536		20	27	27	105	9
10	Floor Tiles	2001	2,137		20	107	107	410	10
11	Plumbing Repair In M	2001	2,031		20	102	102	390	11
12	Electrical Supplies	2001	1,574		20	79	79	302	12
13	Bathroom Remodeling	2001	1,000		20	50	50	192	13
14	Bathroom Remodeling	2001	1,200		20	60	60	230	14
15	Paint	2001	1,351		20	68	68	243	15
16	Landscaping	2001	2,115		20	106	106	379	16
17	Plans For Elec.Work	2001	660		20	33	33	118	17
18	Ac Repair	2001	2,065		20	103	103	362	18
19	Ac Repair	2001	510		20	26	26	90	19
20	Boiler Repair	2001	3,279		20	164	164	560	20
21	Plumbing Repair-Kitc	2001	1,886		20	94	94	322	21
22	Boiler Room Repair	2001	2,160		20	108	108	369	22
23	Sliding Gate	2001	1,840		20	92	92	314	23
24	Firebrick Backup Sys	2001	2,297		20	115	115	383	24
25	Tiles	2001	841		20	42	42	140	25
26	Plumbing Repair	2001	1,057		20	53	53	172	26
27	Carpeting	2001	6,145		20	307	307	973	27
28	Tiles	2001	634		20	32	32	100	28
29	Plumbing Repair	2001	4,000		20	200	200	633	29
30	Plumbing Repair	2001	2,052		20	103	103	325	30
31	Sprinkler System Rep	2001	1,750		20	88	88	278	31
32	Freezer Repair	2002	968		20	65	65	161	32
33	Bathroom Remodeling	2002	20,979		20	2,098	2,098	6,294	33
34	TOTAL (lines 1 thru 33)		\$ 6,568,932	\$ 248,207		\$ 210,022	\$ (38,185)	\$ 1,161,283	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 6,568,932	\$ 248,207		\$ 210,022	\$ (38,185)	\$ 1,161,283	1
2	Water Leak Repair	2002	767		20	77	77	230	2
3	Control Cabinet For Boiler Room	2002	4,670		20	467	467	1,401	3
4	Plumbing Supplies	2002	772		20	77	77	232	4
5	Plumbing Supplies	2002	568		20	57	57	170	5
6	Pump Repair	2002	1,832		20	183	183	550	6
7	Pump Repair	2002	670		20	67	67	201	7
8	Boiler Repair	2002	2,159		20	180	180	540	8
9	Drinking Fountain Installation	2002	509		20	51	51	153	9
10	Tub Leak Repair	2002	647		20	65	65	194	10
11	Shower Lever	2002	600		20	40	40	120	11
12	New Drywall In 3 Bathrooms	2002	12,600		20	1,260	1,260	3,675	12
13	Plumbing Repair	2002	877		20	88	88	256	13
14	Plumbing Repair	2002	2,988		20	299	299	872	14
15	Toilet Repair	2002	541		20	36	36	105	15
16	Electric Wiring	2002	768		20	77	77	218	16
17	Plumbing Repair	2002	661		20	66	66	187	17
18	Paint	2002	957		20	96	96	263	18
19	Paint	2002	1,899		20	190	190	506	19
20	Paint	2002	861		20	86	86	230	20
21	Roof Drain Repair	2002	614		20	61	61	164	21
22	Paint	2002	542		20	54	54	140	22
23	Roof Drain Repair	2002	594		20	59	59	153	23
24	Call Lights Replacement	2002	1,197		20	120	120	309	24
25	Plumbing Repair	2002	866		20	87	87	224	25
26	Landscaping	2002	1,956		20	130	130	337	26
27	Tuckpointing	2002	3,000		20	300	300	750	27
28	Key By Code	2002	852		20	85	85	213	28
29	Builders Hardware	2002	535		20	54	54	129	29
30	Tuckpointing	2002	8,475		20	848	848	2,048	30
31	Fire Escape Repair	2002	5,250		20	525	525	1,269	31
32	Fire Escape Repair	2002	2,500		20	250	250	604	32
33	Tiles	2002	530		20	27	27	64	33
34	TOTAL (lines 1 thru 33)		\$ 6,631,189	\$ 248,207		\$ 216,084	\$ (32,123)	\$ 1,177,790	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 6,631,189	\$ 248,207		\$ 216,084	\$ (32,123)	\$ 1,177,790	1
2	Gaskets Installation	2002	1,135		20	114	114	274	2
3	Drywall	2002	550		20	55	55	128	3
4	Electrical Supplies	2002	1,499		20	150	150	350	4
5	Tuckpointing	2002	1,700		20	170	170	397	5
6	Quarter Round (455)	2002	699		20	70	70	157	6
7	Vct Tile	2002	2,007		20	201	201	452	7
8	Paint	2002	2,939		20	294	294	661	8
9	Duro-Last Roof	2002	2,900		20	290	290	653	9
10	Window Lintel Replacement	2002	2,500		20	250	250	563	10
11	Boiler Repair	2002	1,455		20	121	121	273	11
12	Thermopak Boiler	2002	1,425		20	119	119	267	12
13	Vct Tile	2002	641		20	64	64	144	13
14	Thermopack Boiler	2002	7,856		20	655	655	1,418	14
15	Elevator Repair	2002	3,741		20	187	187	405	15
16	Paint	2002	695		20	70	70	151	16
17	Replace Piping	2002	1,325		20	133	133	287	17
18	Replace Piping	2002	802		20	80	80	174	18
19	Lintel Replacement	2002	21,000		20	2,100	2,100	4,550	19
20	Water Leak Repair-Boiler Room	2002	987		20	99	99	296	20
21	Shower Doors	2002	1,095		20	219	219	602	21
22	Ac	2002	603		20	86	86	215	22
23	Ac	2002	2,995		20	428	428	1,070	23
24	Plumbing Supplies	2002	703		20	141	141	340	24
25	Ac	2002	2,236		20	319	319	772	25
26	Tiles	2002	2,634		20	263	263	549	26
27	Paint	2002	1,832		20	183	183	382	27
28	Stream Lines Leak Repairs	2003	9,731		20	487	487	973	28
29	Electrical Supplies	2003	620		20	31	31	62	29
30	Radiators Repairs	2003	1,043		20	52	52	104	30
31	Tiles	2003	823		20	41	41	82	31
32	Elevator Repair	2003	1,235		20	62	62	118	32
33	Elevator Repair	2003	4,297		20	215	215	394	33
34	TOTAL (lines 1 thru 33)		\$ 6,716,892	\$ 248,207		\$ 223,833	\$ (24,374)	\$ 1,195,053	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 6,716,892	\$ 248,207		\$ 223,833	\$ (24,374)	\$ 1,195,053	1
2	<u>New Shower Base</u>	2003	1,203		20	60	60	110	2
3	<u>Tiles</u>	2003	544		20	27	27	50	3
4	<u>Ceiling Tiles</u>	2003	825		20	41	41	76	4
5	<u>Repair Rooms From Water Damage</u>	2003	12,500		20	625	625	1,094	5
6	<u>Repair Rooms From Water Damage</u>	2003	1,750		20	88	88	146	6
7	<u>Painting Supplies</u>	2003	618		20	31	31	44	7
8	<u>Install Relief Valve</u>	2003	700		20	35	35	50	8
9	<u>Leasehold Improvements</u>	2003	1,375		20	69	69	97	9
10	<u>Leasehold Improvements</u>	2003	1,131		20	57	57	75	10
11	<u>Leasehold Improvements</u>	2003	703		20	35	35	47	11
12	<u>Leasehold Improvements</u>	2003	575		20	29	29	38	12
13	<u>Paint</u>	2003	947		20	47	47	59	13
14	<u>Crafty Beaver</u>	2004	1,611		20	161	161	161	14
15	<u>Repair Elevator Door</u>	2004	715		20	71	71	71	15
16	<u>New Start Components</u>	2004	593		20	59	59	59	16
17	<u>Vinal Tread</u>	2004	587		20	59	59	59	17
18	<u>Locks & Door Knobs</u>	2004	715		20	72	72	72	18
19	<u>Rebuild Boiler</u>	2004	6,791		20	679	679	679	19
20	<u>Reconnect Pipes</u>	2004	15,297		20	1,530	1,530	1,530	20
21	<u>Pilot Repair</u>	2004	1,241		20	124	124	124	21
22	<u>New Pedestal, Lavatory & Faucet</u>	2004	735		20	74	74	74	22
23	<u>Boiler Treatment</u>	2004	1,085		20	217	217	217	23
24	<u>Steam Piping Work</u>	2004	6,207		20	569	569	569	24
25	<u>Burner Repair & Parts</u>	2004	1,271		20	116	116	116	25
26	<u>Bathroom & Hot Water Repair</u>	2004	676		20	62	62	62	26
27	<u>Weather Stripping, Plaster, Concrete</u>	2004	692		20	63	63	63	27
28	<u>Kitchen</u>	2004	2,788		20	256	256	256	28
29	<u>3 Toilet Bowls & Tanks</u>	2004	590		20	108	108	108	29
30	<u>Floor Tiles</u>	2004	1,170		20	98	98	98	30
31	<u>Repair Electrical Service Boxes</u>	2004	1,378		20	115	115	115	31
32	<u>Two New Toilets -- Labor & Materials</u>	2004	1,118		20	93	93	93	32
33	<u>Water Piping</u>	2004	844		20	70	70	70	33
34	TOTAL (lines 1 thru 33)		\$ 6,785,867	\$ 248,207		\$ 229,573	\$ (18,634)	\$ 1,201,535	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 6,785,867	\$ 248,207		\$ 229,573	\$ (18,634)	\$ 1,201,535	1
2	Piping	2004	2,197		20	183	183	183	2
3	Boiler Repair	2004	1,840		20	153	153	153	3
4	Boiler Repair	2004	8,764		20	730	730	730	4
5	Replace Motor On Pump	2004	671		20	56	56	56	5
6	Electrical Repairs	2004	924		20	77	77	77	6
7	Lock & Key Repairs	2004	828		20	69	69	69	7
8	Installed New Compressor	2004	750		20	56	56	56	8
9	Hot Water Repairs	2004	839		20	63	63	63	9
10	Repaired Steam Leaks	2004	4,027		20	302	302	302	10
11	Toilet Bowls	2004	892		20	59	59	59	11
12	Sales Tax On Tiles	2004	72		20	5	5	5	12
13	Sales Tax	2004	181		20	12	12	12	13
14	Metal Hinge Covers	2004	643		20	43	43	43	14
15	3 New Pilot Assemblies On Boiler	2004	1,203		20	70	70	70	15
16	New Entrance Door	2004	6,000		20	300	300	300	16
17	20 Ez Stands	2004	616		20	31	31	31	17
18	Floor Tiles	2004	535		20	22	22	22	18
19	New Circuit Breaker For Elevator	2004	331		20	14	14	14	19
20	New 200 Amp Service	2004	9,000		20	375	375	375	20
21	Plumbing Parts	2004	639		20	21	21	21	21
22	Walk In Freezer Repair	2004	1,106		20	37	37	37	22
23	New Circuits & Outlets	2004	1,500		20	50	50	50	23
24	Various Tools	2004	643		20	21	21	21	24
25	Plywood, Glue Tape Etc.	2004	694		20	17	17	17	25
26	Plumbing Fixtures, Supplies	2004	890		20	22	22	22	26
27	Boiler Repair	2004	1,447		20	36	36	36	27
28	Door Closers - Hardware	2004	916		20	23	23	23	28
29	Boiler Repairs	2004	1,501		20	25	25	25	29
30	Cubicle Curtains	2004	1,603		20	27	27	27	30
31	Cubicle Curtains	2004	1,340		20	22	22	22	31
32	Cubicle Curtains	2004	1,340		20	22	22	22	32
33	Electrical - Plumbing Parts - Cabinets	2004	1,292		20	43	43	43	33
34	TOTAL (lines 1 thru 33)		\$ 6,841,091	\$ 248,207		\$ 232,559	\$ (15,648)	\$ 1,204,521	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 6,841,091	\$ 248,207		\$ 232,559	\$ (15,648)	\$ 1,204,521	1
2	Plate Glass	2004	670		20	6	6	6	2
3	Paints	2004	627		20	5	5	5	3
4	Boiler Treatment	2004	1,159		20	10	10	10	4
5	Repairs To Fire Alarm	2004	1,061		20	9	9	9	5
6	Replace Smoke Detector	2004	2,122		20	18	18	18	6
7	Repair To Hot Water	2004	512		20	4	4	4	7
8	Elevator Lock & Keeper	2004	668		20	22	22	22	8
9	Elevator Coil	2004	720		20	21	21	21	9
10	Elevator Contact Kit	2004	619		20	18	18	18	10
11	Elevator Concts & Stop	2004	774		20	23	23	23	11
12	Paint	2004	1,819		20	91	91	91	12
13	Paint	2004	746		20	37	37	37	13
14	Paint	2004	532		20	22	22	22	14
15	Paint	2004	627		20	24	24	24	15
16	Paint	2004	1,574		20	26	26	26	16
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19									19
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,855,321	\$ 248,207		\$ 232,895	\$ (15,312)	\$ 1,204,857	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 6,855,321	\$ 248,207		\$ 232,895	\$ (15,312)	\$ 1,204,857	1
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29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,855,321	\$ 248,207		\$ 232,895	\$ (15,312)	\$ 1,204,857	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$ 6,855,321	\$ 248,207		\$ 232,895	\$ (15,312)	\$ 1,204,857	1
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,855,321	\$ 248,207		\$ 232,895	\$ (15,312)	\$ 1,204,857	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 6,855,321	\$ 248,207		\$ 232,895	\$ (15,312)	\$ 1,204,857	1
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32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,855,321	\$ 248,207		\$ 232,895	\$ (15,312)	\$ 1,204,857	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 6,855,321	\$ 248,207		\$ 232,895	\$ (15,312)	\$ 1,204,857	1
2									2
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4									4
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 6,855,321	\$ 248,207		\$ 232,895	\$ (15,312)	\$ 1,204,857	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Grasmere Place

0044271

Report Period Beginning:

01/01/04

Ending:

12/31/04

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	216		1999		\$ 5,578,000	\$ 143,026	35	\$ 159,371	\$ 16,345	\$ 942,945	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Grasmere Real Estate LLC		1999		192,580	9,629	20	9,629		54,564	9
10	Grasmere Real Estate LLC		1999		19,311	966	20	966	(0)	5,313	10
11	Grasmere Real Estate LLC		1999		1,573	79	20	79	(0)	428	11
12	Grasmere Real Estate LLC		1999		50,131	2,507	20	2,507	0	13,371	12
13	Grasmere Real Estate LLC		1999		17,558	1,756	10	1,756		5,488	13
14	Grasmere Real Estate LLC		1999		90,718	4,536	20	4,536	(0)	23,436	14
15	Grasmere Real Estate LLC		2003		614	61	20	31	(30)	62	15
16	Grasmere Real Estate LLC		2003		29,291	2,929	20	1,465	(1,464)	2,930	16
17	Grasmere Real Estate LLC		2003		11,000	1,100	20	550	(550)	1,100	17
18	Grasmere Real Estate LLC		2003		2,700	386	20	135	(251)	270	18
19	Grasmere Real Estate LLC		2003		1,885	189	20	94	(95)	188	19
20	Grasmere Real Estate LLC		2003		595	60	20	30	(30)	60	20
21	Grasmere Real Estate LLC		2003		7,651	1,093	20	383	(710)	734	21
22	Grasmere Real Estate LLC		2003		15,949	1,063	20	797	(266)	1,462	22
23	Grasmere Real Estate LLC		2003		13,280	885	20	664	(221)	1,217	23
24	Grasmere Real Estate LLC		2003		1,511	151	20	76	(75)	139	24
25	Grasmere Real Estate LLC		2003		736	74	20	37	(37)	62	25
26	Grasmere Real Estate LLC		2003		1,299	87	20	65	(22)	103	26
27	Grasmere Real Estate LLC		2003		852	57	20	43	(14)	68	27
28	Grasmere Real Estate LLC		2003		13,067	871	20	653	(218)	1,034	28
29	Grasmere Real Estate LLC		2003		12,320	821	20	616	(205)	975	29
30	Grasmere Real Estate LLC		2003		659	66	20	33	(33)	49	30
31	Grasmere Real Estate LLC		2003		521	52	20	26	(26)	39	31
32	Grasmere Real Estate LLC		2004		532	443	20	27	(416)	27	32
33	Grasmere Real Estate LLC		2004		715	72	20	36	(36)	36	33
34	Grasmere Real Estate LLC		2004		2,067	207	20	103	(104)	103	34
35	Grasmere Real Estate LLC		2004		1,045	87	20	52	(35)	52	35
36	Grasmere Real Estate LLC		2004		1,100	73	20	55	(18)	55	36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Grasmere Real Estate LLC	2004	\$ 642	\$ 27	20	\$ 32	\$ 5	\$ 32	37
38	Grasmere Real Estate LLC	2003	693	58	20	35	(23)	35	38
39	Grasmere Real Estate LLC	2003	1,170	98	20	59	(40)	59	39
40	Grasmere Real Estate LLC	2003	1,095	91	20	55	(36)	55	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
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57									57
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59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 6,072,860	\$ 173,600		\$ 184,992	\$ 11,393	\$ 1,056,491	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4	2201 Main LLC			2002	\$ 24,415	\$ 610	40	\$ 610	\$	\$ 1,526	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Allocation - 2201 Main LLC			2002	20,169	1,008	20	1,008		2,521	9
10	Allocation - 2201 Main LLC			2003	23,768	1,188	20	1,188		1,783	10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
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57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$68,352	\$2,806		\$2,806	\$	\$5,830	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,574,989	\$223,020	\$157,052	\$(65,969)	10	\$908,222	71
72	Current Year Purchases	96,430	16,998	16,630	(368)	10	16,630	72
73	Fully Depreciated Assets	7,742				10	7,742	73
74								74
75	TOTALS	\$1,679,161	\$240,018	\$173,682	\$(66,337)		\$932,594	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76		ESCORT	2001	\$8,270	\$1,654	\$827	\$(827)	5	\$2,688
77		VOLKSWAGEN NEW BEETLE	2002	11,329	2,022	2,022		5	6,610
78		Allocation Care Centers		34,934	2,581	2,581		5	29,055
79									
80	TOTALS			\$54,533	\$6,257	\$5,430	\$(827)		\$38,353

E. Summary of Care-Related Assets					1	2
		Reference			Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$9,406,732	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$494,482	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$412,007	
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$(82,475)	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$2,175,804	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from Care Centers				5,827			5
6								6
7	TOTAL				\$ 5,827			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease

9. Option to Buy:
- YES
- NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- YES
- NO
16. Rental Amount for movable equipment: \$ 13,328
- Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$
13.	/2006	\$
14.	/2007	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

☐

☐

☐

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

☐

☐

B. EXPENSES

		ALLOCATION OF COSTS		(d)	
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost						
					Units	Cost				
1	Licensed Occupational Therapist	N/A	hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental									13
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 16,754	\$ 47,824	1
2	Cash-Patient Deposits	35,715	35,715	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,140,435	1,140,435	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	141,960	169,390	6
7	Other Prepaid Expenses	3,281	3,281	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See Attached Schedule	2,769,713	3,515,640	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 4,107,858	\$ 4,912,285	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		800,000	13
14	Buildings, at Historical Cost		5,578,000	14
15	Leasehold Improvements, at Historical Cost	670,373	1,159,121	15
16	Equipment, at Historical Cost	221,781	1,593,114	16
17	Accumulated Depreciation (book methods)	(381,863)	(2,473,480)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Attached Schedule		816,139	23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 510,291	\$ 7,472,894	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 4,618,149	\$ 12,385,179	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 477,795	\$ 477,796	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	27,290	27,290	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	159,771	159,771	30
31	Accrued Taxes Payable (excluding real estate taxes)	10,204	10,204	31
32	Accrued Real Estate Taxes(Sch.IX-B)		197,746	32
33	Accrued Interest Payable		44,142	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 675,060	\$ 916,949	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		9,408,578	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Attached Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 9,408,578	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 675,060	\$ 10,325,527	46
47	TOTAL EQUITY(page 18, line 24)	\$ 3,943,089	\$ 2,059,652	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 4,618,149	\$ 12,385,179	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$3,583,651	1
2	Restatements (describe):		2
3	See Attached	(277,158)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$3,306,493	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	961,596	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(325,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$636,596	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$3,943,089	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 6,496,002	1
2	Discounts and Allowances for all Levels	(137)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 6,495,865	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	15	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	122	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 137	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	199,624	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 199,624	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	309	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 309	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 6,695,935	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,144,369	31
32	Health Care	1,876,958	32
33	General Administration	1,529,910	33
	B. Capital Expense		
34	Ownership	1,064,518	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	118,584	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,734,339	40
41	Income before Income Taxes (line 30 minus line 40)**	961,596	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 961,596	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? not complete If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,240	1,481	\$ 43,484	\$ 29.36	1
2	Assistant Director of Nursing	1,749	2,254	60,686	26.92	2
3	Registered Nurses	2,169	2,392	60,885	25.45	3
4	Licensed Practical Nurses	14,597	16,015	308,968	19.29	4
5	Nurse Aides & Orderlies	55,671	59,751	499,904	8.37	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,806	2,056	38,488	18.72	9
10	Activity Assistants	7,269	8,236	66,380	8.06	10
11	Social Service Workers	28,632	32,665	507,059	15.52	11
12	Dietician					12
13	Food Service Supervisor	3,568	4,046	48,056	11.88	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,473	15,853	130,216	8.21	15
16	Dishwashers					16
17	Maintenance Workers	10,923	11,881	101,320	8.53	17
18	Housekeepers	24,285	26,438	208,536	7.89	18
19	Laundry					19
20	Administrator	1,774	2,198	89,262	40.61	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	10,337	11,523	118,248	10.26	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,414	2,543	22,205	8.73	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental	27,892	28,248	144,885	5.13	33
34	TOTAL (lines 1 - 33)	208,799	227,580	\$ 2,448,582 *	\$ 10.76	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	232	\$ 9,973	01-03	35
36	Medical Director	monthly	7,200	09-03	36
37	Medical Records Consultant	monthly	4,120	10-03	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	2,550	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	15	717	11-03	44
45	Social Service Consultant	11	552	12-03	45
46	Other(specify) Psycho-Social	54	2,700	12-03	46
47	Art Therapist Consultant	235	11,738	11-03	47
48	CCI Cost - See Attached		7,884	various	48
49	TOTAL (lines 35 - 48)	547	\$ 47,434		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	327	\$ 15,833	10-03	50
51	Licensed Practical Nurses	518	16,851	10-03	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	845	\$ 32,684		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount	
Celeste Jensen	Administrator	0	\$ 89,262	Workers' Compensation Insurance		\$ 46,146	IDPH License Fee		\$	
				Unemployment Compensation Insurance		52,333	Advertising: Employee Recruitment		13,343	
				FICA Taxes		186,319	Health Care Worker Background Check			
				Employee Health Insurance		115,401	(Indicate # of checks performed 152)		2,127	
				Employee Meals		32,794	Dues & Subscriptions		9,698	
				Illinois Municipal Retirement Fund (IMRF)*			Licenses & Fees		3,426	
				Chicago Employer Tax		5,120	Advertising & Promotion		19,952	
				Employee Physicals		552	Allocation from Care Centers		3,482	
				Pension		12,849				
				Holiday Expense		3,285				
				Other Employee Benefit		1,739				
							Less: Public Relations Expense		()	
							Non-allowable advertising		(19,952)	
							Yellow page advertising		()	
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		\$ 456,538	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 32,076	
(List each licensed administrator separately.)			\$ 89,262							
B. Administrative - Other										
Description			Amount							
Management Fees - Eric Rothner			\$ 9,713							
Management Fees - Nathan Langsner			12,000							
Administrative payroll allocated from Care Centers			2,630							
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 24,343							
(Attach a copy of any management service agreement)										
C. Professional Services										
Vendor/Payee	Type	Amount		Description		Line #	Amount		Description	Amount
Care Centers Inc.	Home Office Expense	\$	181,440				\$		Out-of-State Travel	\$
Care Centers Inc.	Ancillary Admin. Expense		25,920							
Care Centers Inc.	Bookkeeping Fees		44,064							
Care Centers Inc.	Data Processing		7,776						In-State Travel	
ADP	Payroll Services		12,695							
Care Centers Inc.	Accounting		15,000							
Frost, Ruttenberg & Rothblatt	Accounting		27,541							
Care Centers Inc.	Legal		19,710						Seminar Expense	1,241
Various - see attached	Legal		21,175						Educational Expense	91
Legat Architects	Annual Code Review		4,722						Allocation from Care Centers	4,960
Personnel Planners	Unemployment Consultant		4,473							
See Supplemental Schedule			529						Entertainment Expense	()
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL		\$	(agree to Sch. V, line 24, col. 8)			
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 365,045				TOTAL			\$ 6,292

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. ICLTC \$10,342
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line _____
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 118,584
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 32,794 Has any meal income been offset against related costs? No Indicate the amount. \$ _____
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100% ln14
d. Have vehicle usage logs been maintained? No
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.